Personal Representative Form

Use this form to identify a person who can:

- Make decisions about your health care
- Request and disclose your protected health information (PHI)
- Exercise your rights on your behalf

A Personal Representative may be legally appointed or designated by the member or patient to act on their behalf. For Personal Representatives that have been legally appointed, the Personal Representative can complete this form and attach supporting legal documentation, such as a Power of Attorney that indicates full health care decision-making authority, guardianship documentation, etc.

- Your Personal Representative will be able to direct us to disclose your PHI to third parties and request your records on your behalf. If you choose, they will also be able to make certain treatment decisions on your behalf. If you do not wish to give them those powers, please complete an Authorization to use and disclose PHI form instead.

Member or patient information

First name	Middle initial	Last name
Member or patient ID	Date of birth	Phone number
Mailing address		
City	State	ZIP code

If request is being made by a parent or guardian of a minor child, complete the following:
Member or patient is a minor, __ years of age.

If you are making this request on behalf of a minor child, we may require additional information before this request will be processed.

Personal Representative information

First name	Middle initial	Last name
Mailing address		
City	State	ZIP code
Relationship to member or patient	Phone number	

For requests completed by Personal Representatives, a copy of a Power of Attorney or other legal documents must be attached to this form before we can process this request. Forms submitted without supporting documents may be rejected.

Description and purpose of disclosure

Select the company that applies to your request*:	**The following items require special consent by law.**
☐ Star Medical Associates	Check the boxes below to indicate your intent to include:
	□ Alcohol or substance abuse □ Genetic information □ HIV / AIDS □ Mental or behavioral health
* If a selection is not made, this authorization will apply to all Star businesses with which you have an account.	□ Reproductive Health

This Personal Representative designation will remain in effect until we receive a written request from you to revoke the access; and/or your Personal Representative notifies us they are no longer acting on your behalf.

By signing below, I understand that I am authorizing the use and release of my PHI, and:

1. I understand I am giving permission for written information to be released and for my Personal Representative to speak on my behalf.
2. My written consent is voluntary. I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment.
3. If my Personal Representative is not subject to federal or state health information privacy laws, they may further release my health information and it may no longer be protected by federal and state privacy laws.
4. I may revoke or cancel this request at any time by sending written request to the address at the bottom of this form. I understand that any revocation or cancelation will not affect any action taken by Star before the revocation was received.

Treatment decisions (optional)

□ The Personal Representative listed on this form has my permission to make treatment decisions on my behalf. These decisions include transferring my prescriptions, enrolling me in pharmacy programs, providing direction to my care providers, making decisions related to my pharmacy care and related services.

Signature

A. Personal Representatives designated by member or patient:
I have read and understand the above information. I acknowledge that by signing this form I authorize STAR and its affiliates to treat my Personal Representative as myself.

Signature of member or patient: _____ Date: _____

B. Personal Representatives who are legally appointed:
I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the member or patient, and I am attaching supporting documentation.

Signature of Personal Representative: _____ Date: _____

Mail the completed form to:

STAR
PO Box 227, Burbank,
CA 91503
1-818-746-3616

Or, fax the completed form to:

1-818-746-3782

Star MEDICAL